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Article (Unspecified)

Clinical Case Studies
2014, Vol. 13(4) 322–335

DOI: 10.1177/1534650113510398
ccs.sagepub.com
SAGE

Involving Parents in Cognitive-Behavioral Therapy for Child Anxiety Problems: A Case Study

Andy P. Siddaway[1], Alex M. Wood[2], and Sam Cartwright-Hatton[3]

Abstract

This case study examines how parents can be incorporated into all aspects of cognitive-behavioral therapy (CBT) for child anxiety problems. This is an important issue, because although there are strong theoretical and empirical reasons for incorporating parents into treatment, evidence from randomized controlled trials has so far been inconclusive about whether outcomes are improved by involving parents. This case study describes the clinical benefits of a balanced focus on parent and child factors for "Laura," an 8-year-old girl experiencing a range of fears and worries, including refusing to attend school. Treatment consisted of seven sessions of CBT, which targeted parent and child factors hypothesized to be critical to the development and maintenance of Laura's anxiety problems. The clinician's decision making and reasoning in carefully selecting CBT interventions to specifically address the presenting problems are illustrated. Laura showed marked reductions in avoidance behaviors and fears and returned full-time to school.

Keywords

child anxiety, cognitive-behavioral therapy, theory

1 Theoretical and Research Basis for Treatment

Anxiety disorders are among the most common psychological problems of childhood and adolescence (Kessler et al., 2005; Rapee, Schniering, & Hudson, 2009). Studies indicate that approximately 2.5% to 5% of children and adolescents meet criteria for an anxiety disorder at any one time (e.g., Costello, Mustillo, Erkanli, Keeler, & Angold, 2003; Ford, Goodman, & Meltzer, 2003). Anxiety disorders in childhood present a major concern for clinicians and researchers alike because they can have significant and long-term negative consequences on cognitive development (Creswell & Cartwright-Hatton, 2007), school performance (Essau, Conradt, & Petermann, 2000), and social and family functioning (Wood & McLeod, 2008). They are also associated with the development of other disorders, such as depression, conduct disorder, and attention deficit disorder (Bittner et al., 2007; Woodward & Fergusson, 2001), and increase the

[1]University of Hertfordshire, Hatfield, UK
[2]Behavioural Science Centre, Stirling Management School, University of Stirling, Stirling, UK
[3]University of Sussex, Brighton, UK

Corresponding Author:
Andy P. Siddaway, Department of Psychology, University of Hertfordshire, Hatfield AL10 9AB, UK.
Email: andysiddaway@gmail.com

risk of anxiety disorders in adulthood (Kim-Cohen et al., 2003). As a result of these concerns, research into childhood anxiety disorders has burgeoned in recent years. A number of authors have reviewed the literature relating to risk factors, onset, theoretical explanations, and treatments (e.g., Chorpita & Barlow, 1998; Creswell & Cartwright-Hatton, 2007; Farmer, Eley, & McGuffin, 2005; Field, 2006; Field & Lester, 2010; McLeod, Wood, & Weisz, 2007; Mineka & Zinbarg, 2006; Murray, Creswell, & Cooper, 2009; Rapee et al., 2009; Stallard, 2005; Wood, McLeod, Sigman, Hwang, & Chu, 2003). Across these reviews, there is a clear consensus that the development and maintenance of child anxiety problems is due to a complex and dynamic interplay of neurobiological, developmental, temperament, psychosocial, and parenting factors.

Numerous clinical trials have demonstrated that cognitive-behavioral therapy (CBT) is a highly effective treatment for childhood anxiety disorders, regardless of format (Breinholst, Esbjørn, Reinholdt-Dunne, & Stallard, 2012; Hudson et al., 2009; In-Albon & Schneider, 2007; James, Soler, & Weatherall, 2005). Given significant and consistent evidence regarding the potential influence of parental risk factors in the development and maintenance of child anxiety problems (see the reviews cited above), various trials have evaluated whether including parents in treatment confers an additional benefit to solely working with young people. In addition to potentially targeting important parental risk factors, there are also strong theoretical reasons for including parents in the treatment of child anxiety problems. For instance, as a result of this input, parents may learn alternative, more constructive ways of thinking, behaving, and parenting, which could enhance the child's treatment effect by removing important risk factors and adding important protective factors (Cartwright-Hatton, Laskey, Rust, & McNally, 2010; Stallard, 2005). Parental involvement in treatment may also facilitate and reinforce the successful learning, maintenance, and generalization of new skills and perspectives into the child's and family's everyday life, during and after treatment (Spence, Donovan, & Brechman-Toussaint, 2000; Stallard, 2005).

However, to date, parental involvement in the treatment of child anxiety problems has often been done in an idiosyncratic and atheoretical fashion, leading to inconsistent and confusing randomized controlled trial results (Creswell & Cartwright-Hatton, 2007). For instance, in some treatment programs, parents were involved minimally; whereas in others, they were actively involved throughout treatment. For this reason, the trials incorporating parents in treatment have been reviewed to explore why, despite strong theoretical and empirical reasons, parental involvement has not clearly and consistently enhanced outcomes so far (Breinholst et al., 2012; Creswell & Cartwright-Hatton, 2007). These reviews highlight a number of factors that might account for the current results, and they identify large variation in how many and which of the empirically derived parental factors have been targeted and measured in treatment studies (Breinholst et al., 2012; Creswell & Cartwright-Hatton, 2007).

In this article, we present a case study that illustrates in detail how parents can be involved in all stages of CBT for child anxiety. We outline a flexible, individualized approach to CBT assessment, formulation, and treatment (Kuyken, Padesky, & Dudley, 2009; Persons, 2008) that appears to have been relatively absent in the literature to date (Breinholst et al., 2012; Creswell & Cartwright-Hatton, 2007), and demonstrate how specific CBT techniques were carefully selected to target only those factors seen to be critical to the maintenance of child anxiety problems for this specific family, at this specific time. In providing an individualized, tailored approach, we address concerns raised by Breinholst et al. (2012) that child anxiety treatments need to be "tailored to the specific family rather than strictly adhering to structured manuals" (p. 422) and that parental treatments to date have targeted too many things at once—in doing so, "failing to target any one behaviour adequately" (p. 422). We illustrate how parents can be incorporated into every stage of child anxiety CBT by describing the interplay between child anxiety theory and evidence, emerging clinical information, and the clinician's thinking and decision making.

2 Case Introduction

"Laura" was an 8-year-old White-British girl referred for psychological therapy by her general practitioner. She was seen in a U.K. Tier 3 Child and Adolescent Mental Health Service (CAMHS). The therapist was a 2nd-year male graduate student in clinical psychology with 7 years of clinical practice experience. He was supervised by a qualified clinical psychologist.

3 Presenting Complaints

Laura and her parents described various anxiety problems that manifested as reluctance to attend school, reduced engagement with schoolwork and other children, being sent home from school due to fears, and avoidance of everyday places (e.g., visiting familiar shops) and previously enjoyed hobbies (e.g., dance class). At the start of therapy, these fears had worsened to the extent that Laura had recently stopped attending school.

4 History

Laura's parents reported that her upbringing was stable, her developmental milestones were met without incident, and that there had not been any significant life events or difficulties. They reported that Laura had worried about a range of things for many years, that she had a sensitive and anxious personality, and that she was very attuned to and aware of other people's feelings. Laura's mother reported that she herself had felt very anxious at school when she was Laura's age and that her mother in turn had been "a worrier." Parent reports indicated that Laura's avoidant behaviors appeared to have started shortly after the relatively recent death of her maternal grandfather. Laura previously had infrequent contact with her grandfather and her relationship with him was described as not being particularly close.

5 Assessment

Laura and her parents attended the assessment. As is customary in U.K. CAMHS, the Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997) was completed pre- and post-treatment (see Table 2). Laura's age meant that only the parent version could be completed. The SDQ consists of 25 items covering five subscales and has good reliability and validity (Goodman, 2001).

A detailed clinical interview was also conducted, which followed Stallard's (2005) "PRECISE" guidelines for working with children (*P*artnership working, *R*ight Developmental Level, *E*mpathy, *C*reative, *I*nvestigation and Experimentation, *S*elf-discovery and efficacy, and *E*njoyable). The clinical interview adopted a balanced coverage of individual and systemic predisposing, precipitating, perpetuating, and protective factors (Stallard, 2005). In terms of family constellation factors that may be relevant when interpreting this case, Laura has an older sister aged 11 years, but Laura's parents reported that the sister has a more extroverted and confident personality and did not have any mental health problems. Laura's sister did not attend any of the therapy sessions as this was not clinically indicated and the sessions took place in school time. Laura's parents are 40 to 45 years old and both in professional jobs. They reported a solid relationship together, although this was not formally assessed. Laura's parents presented as very nurturing, gentle, and concerned toward Laura.

Laura presented as very shy during the assessment session (sitting on her father's lap and timidly answering "don't know" to the initial rapport-building and scene-setting questions). The clinician adapted to this presentation by asking Laura to draw a picture of her school, with the rationale that a picture might provide further useful information about key cognitions while also making the focus of the session less intense for Laura, thereby facilitating engagement. While Laura was

drawing, her parents described how she had now missed six weeks of school and outlined the gradual expansion of her avoidant behaviors over time. Information on developmental factors, presenting problems, family functioning, and how Laura's fears were parented, was elicited (Stallard, 2005). The clinician also elicited Laura's parents' cognitions around the anxiety problems, validated concerns and frustrations, and tried to provide hope for change. Laura's parents viewed the anxiety problems in a similar way. Various potential difficulties at school (e.g., social difficulties with friends or teachers, academic/neurocognitive difficulties, bullying) were explored and ruled out. Laura had not received any form of intervention prior to this referral and was not taking any medication. Laura's parents denied any mental health problems themselves.

During the assessment, the clinician alternated between talking with Laura and talking with her parents, with the aim that everyone felt equal, valued, and validated. The discussion included some problem-free talk about untroubled areas of the family's life in order to gain a broader picture of the family and identify strengths that could be used in treatment (Kuyken et al., 2009). Recent examples of difficulties were discussed, as well as exceptions where Laura had faced her fears. The clinician was careful here to balance eliciting information, understanding and validating problems, and searching for strengths that had been overlooked by the family. This approach not only helped the family feel understood but also began to open up new behavioral possibilities and move the family toward their goals (Kuyken et al., 2009). Laura's drawing (a positive image of her next to school buildings) was consistent with her own and her parents' verbal reports (i.e., that her school avoidance was not due to avoidance of bullying, for example). The drawing put Laura at ease and she and the clinician were able to chat about the drawing and then about Laura's fears. When more relaxed, Laura reported that she was often concerned about vomiting when she feels anxious and that she wanted to return to school. Laura could not explain her school avoidance; her developmental level meant that specific cognitions either were not present or could not be described, so the clinician inferred key cognitions from discussions of triggers and from parent reports. Each person's stage of change was also assessed, for example, by asking how much each person would like the problems to go away and why. There was no information to suggest that Laura's symptoms provided a "secondary gain" for any family member. A plan was made that Laura's parents would liaise with her school to pass on to teachers the therapeutic strategies suggested in sessions. The assessment ended with a brief discussion that the forthcoming therapy together would involve graded exposure.

6 Case Conceptualization

The presenting problems were fear and worry around being independent or being in unfamiliar environments, avoidance of a range of places and experiences as a way to to cope with these fears, and misinterpreting anxiety symptoms as a sign that Laura might vomit. In keeping with the literature, multiple interacting individual and systemic factors were considered when making sense of this case. The reported and observed information suggested that Laura has an anxious temperament and attachment style, and that this may have been learned or inherited in part from her mother's side of the family. These factors may have led to Laura being more vulnerable to developing anxiety problems. Laura's developmental level may have also acted as a predisposing factor because (a) fears about independence are common in children her age, (b) parents supply the majority of information about the world to children, and (c) an 8-year-old's cognitive style is more global and categorical (e.g., good vs. bad), making nuanced understanding less likely (Grave & Blissett, 2004; Stallard, 2005).

An interactional perspective was used to conceptualize the development and maintenance of Laura's presenting problems. The death of Laura's maternal grandfather was hypothesized to have led to changes within the family (e.g., increased expression of distress by Laura's mother in particular); Laura's sensitive temperament and close attunement to other's feelings meant that she may have responded to the death and the systemic changes by becoming more anxious (i.e., developing an

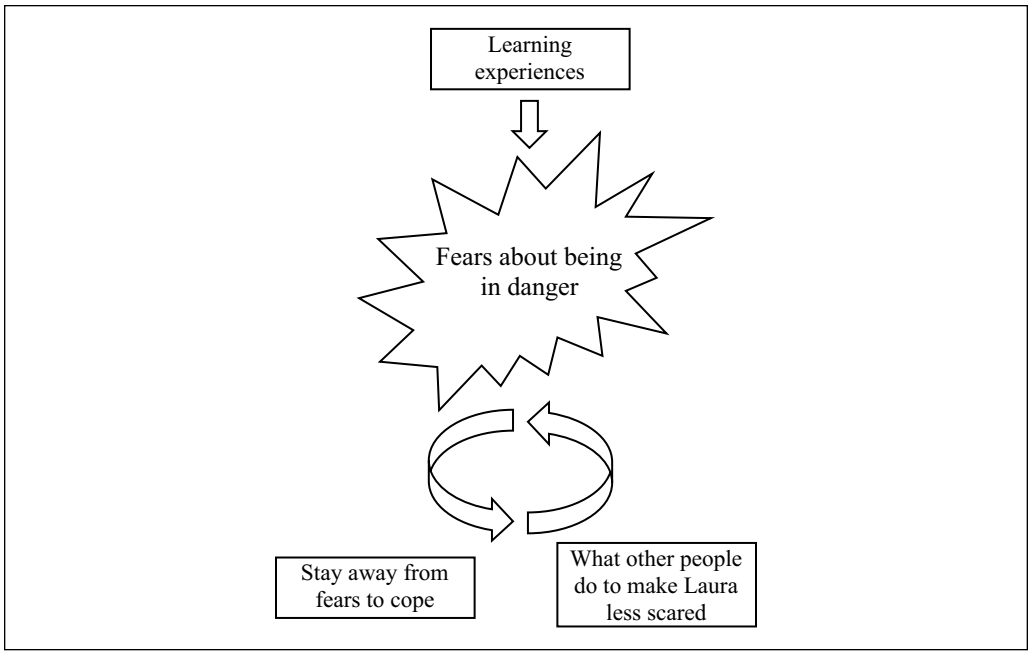

Figure 1.

increased sense of danger and vulnerability with regard to herself and others). Laura's parents may have (understandably) encouraged her avoidance and taken control of situations that caused anxiety for Laura as a way to relieve her distress in the short term (Moore, Whaley, & Sigman, 2004; Wood et al., 2003). While Laura's parents did not present with or report their own anxiety or other mental health problems, they expressed difficulty in tolerating Laura's anxiety or distress and did not generally reinforce Laura's independent coping skills or use of "trial and error" learning, which would have fostered self-efficacy (Cartwright-Hatton et al., 2010). An understandable desire to protect Laura may have become overdeveloped to the point where a message of danger was inadvertently communicated and Laura became increasingly vigilant to threat. Reinforcement of avoidance by school and parents may, in turn, have been interpreted by Laura as further evidence of danger. Laura's mother's experience of childhood anxiety problems probably influenced how she parented Laura's fears (e.g., by encouraging avoidance and taking control of situations that caused anxiety for Laura), and Laura's father may have adopted the same strategy to support his wife.

At an individual level, various maintaining cycles were apparent, involving avoidance, selective attention, and memory to threat, and some "thinking errors" such as catastrophizing, jumping to conclusions, personalizing, and emotional reasoning (Harvey, Watkins, Mansell, & Shafran, 2004). In response to (inadvertent) danger messages, Laura sought soothing from her attachment figures and became less independent, which may have been interpreted by her parents as evidence of needing to continue support of this nature.

Although the clinician made sense of this case using all of the above information, Laura's developmental level and clinical presentation meant that the clinician shared only a very simple diagrammatic formulation with the family (Figure 1). The formulation illustrated to the family that Laura's fears were learned (and therefore could be unlearned), that Laura's fears had been predominantly maintained because of experiential avoidance (providing a rationale for exposure), and that other people in Laura's environment were reinforcing Laura's experiential avoidance (providing a rationale for changing parental cognitions and behavior).

Table 1. Laura's Parents' Fear-Maintaining Cognitions and Behaviors and Interventions to Address These.

Fear-maintaining parental cognitions and behaviors	
Parental cognitions	Laura is fragile and incapable; overdeveloped desire to protect Laura; difficulty tolerating Laura's anxiety or distress; inadvertent, regular messages regarding danger and low confidence in Laura's ability to cope with danger; help-seeking behavior from Laura interpreted as evidence to support fear-maintaining cognitions and behaviors
Parental behaviors	Encourage avoidance and take control of situations that cause anxiety for Laura as a way to relieve Laura's and their own distress in the short term
Interventions targeting fear-maintaining parental cognitions and behaviors	
Involve Laura and her parents in sessions	
Explore and reinforce examples of confident behavior and coping	
Highlight strengths and resources in everyone, including overlooked confident behavior	
Explicitly link parental praise and encouragement for Laura's autonomy and independence with movement toward everyone's goals	
Parents liaise with school to support graded exposure and instill self-efficacy in parents	
Provide anxiety psychoeducation (e.g., normalization, ways to cope)	
Create a fear hierarchy and conduct age-appropriate behavioral experiments	
Contrast short- and long-term advantages and disadvantages of exposure for everyone	
Facilitate increased discussion of fears in and out of sessions	
Homework to facilitate regular out-of-session coping discussions and practice	
Consider evidence for and against Laura's fears and alternative perspectives in and out of sessions	
Coping self-talk to facilitate exposure; practice using recent examples from the family	
Explicit, collaborative discussion specifically targeting unhelpful parental cognitions and behaviors, with reference to the evidence base	
Relapse prevention workbook	

7 Course of Treatment and Assessment of Progress

The intervention involved seven sessions over a period of two months. Treatment drew upon evidence-based child anxiety programs (Cartwright-Hatton et al., 2010; Creswell & Willetts, 2007) and literature tailoring CBT for parent and child involvement (e.g., Ginsburg & Schlossberg, 2002; Stallard, 2005). Rather than strictly adhering to a manualized program, treatment specifically targeted the presenting problems and case conceptualization. Table 1 summarizes important parental cognitions and behaviors that were hypothesized to be responsible for the development and maintenance of Laura's anxiety problems, as well as the interventions designed to target these. The intervention is now described session-by-session for clarity, but we note that many of the interventions operated across multiple sessions.

Consistent with evidence demonstrating that involving parents and children in the same sessions generally leads to more positive results (Barrett, 1998), and Laura's age and developmental level (Ginsburg & Schlossberg, 2002; Grave & Blissett, 2004; Stallard, 2005), all sessions involved Laura and her parents. A mixture of models of parental involvement was used throughout treatment (Stallard, 2005): the "co-clinician" model was adopted in sessions aimed at facilitating the successful transfer, generalization, and maintenance of new skills into Laura's and the family's everyday life; the "co-client" model was adopted in sessions aimed at addressing Laura's parents' problem-maintaining cognitions and behavior (Cartwright-Hatton et al., 2010; Spence et al., 2000; Stallard, 2005).

The first treatment session involved a progress update and discussion of how the family had found the previous session. Since the assessment session, Laura had attended half a day of school

every day. Following principles of contingency management and the importance of identifying and elaborating on strengths, the clinician explored these "brave behaviors" in detail to reinforce them (Kuyken et al., 2009; Stallard, 2005). Important but overlooked information (e.g., small examples of confident behavior by Laura, encouragement of independence by Laura's parents) was drawn to attention, and resources for continuation of these behaviors were highlighted in everyone (Kuyken et al., 2009). The clinician also explicitly linked Laura's parents' changed behavior (e.g., praise and encouragement for autonomy and independence) to the family's goals to further reinforce these behaviors. This discussion was tailored to be developmentally and child-appropriate and involved lots of praise, smiles and attention for Laura. The clinician and family then created a hierarchy of Laura's fears, beginning with being in a noisy environment with her parents at the bottom of the fear hierarchy, to being in the loud and busy school canteen at lunchtime without Laura's parents at the top of the fear hierarchy; as well as further engaging Laura, creating a fear hierarchy helped elicit further cognitive information to inform the case conceptualization.

Each session thereafter, the clinician reviewed how far Laura and her parents had progressed toward their goals (0-10) and spent time talking through recent examples of confident behavior to explicitly recognize and make use of the family's strengths (Kuyken et al., 2009). This discussion had a balanced focus on Laura's parents' thoughts and behaviors (about Laura and their own fears) and Laura's own thoughts and behaviors. Because people generally hold distorted beliefs and adopt unhelpful coping behaviors in relation to areas of difficulty, focusing on the family's strengths broadened the focus of attention away from problems and onto possibilities and ways of coping, reconceptualized fears as understandable ways to keep safe, and identified resources for exposure work (Kuyken et al., 2009).

Subjective Units of Distress (SUDs) ratings were introduced to help everyone understand Laura's experiences more and to effectively explore more constructive alternative cognitions. For example, Laura reported feeling 5/10 anxious during a recent exposure experience and then everyone considered why Laura's fears were not 10/10, thereby allowing overlooked alternative information to be brought to attention. The Session 2 progress update revealed that Laura had returned to school full-time after the first intervention session but remained fearful of various experiences inside and outside of school. The majority of Treatment Session 2 was spent discussing the anxiety psychoeducation information pack that the clinician had created. This involved standard anxiety psychoeducation materials (see Stallard, 2005) and was designed to be age-appropriate and interesting and to address Laura's specific concerns. The analogy of a smoke alarm was used to normalize the purpose and workings of anxiety, and the material repeatedly stated that body changes due to anxiety are safe and normal. All parties agreed that the family would read the anxiety psychoeducation pack again together as homework. Following on from the fear hierarchy created in the previous session, a rationale for doing behavioral experiments as graded exposure to fears was also discussed. Example behavioral experiments were Laura going into school assembly (without her parents) and Laura going to an unknown restaurant with her parents. The clinician stressed the importance of parents regularly and actively looking for examples of confident behaviors and then praising these, hoping to shift the family's focus of attention increasingly onto facing fears and Laura's strengths. A plan was made that Laura's parents would continue to liaise with her school to support her graded exposure.

Treatment Session 3 was spent talking through the "Story of the Dragon in the Mountain" as an explanation for the development of anxiety problems through avoidance and a further rationale for doing behavioral experiments (Cartwright-Hatton et al., 2010). Everyone agreed that the family would read and discuss this story again together as homework. This story was one of various metaphors used to make sessions and materials developmentally appropriate and clinically effective (Stallard, 2005). The standard (adult) protocols for planning and conducting behavioral

experiments (e.g., Bennett-Levy et al., 2004) were considered, but these seemed excessive and developmentally inappropriate for Laura's problems.

In the next session, child and parents alike reported that progress was continuing and avoidance and fear had almost disappeared. Although Laura's behavior and some of her parent's behaviors had changed, Laura's parents reported still being concerned to ask Laura to face her fears if she became upset. Therefore, the clinician guided Laura and her parents through a collaborative discussion contrasting the short- and long-term advantages and disadvantages of exposure for Laura and her parents. During this discussion, the clinician was careful to balance not blaming Laura's parents or Laura hearing unhelpful information, while exposing Laura to her parents' open consideration of avoidance. The majority of the session was spent introducing the concept of coping self-talk to facilitate exposure. The clinician explained that coping self-talk needs to be realistic for it to be useful, using the analogy of an airplane pilot who needs to be realistic but hopeful if an engine stops working. Coping self-talk was practiced in vivo using recent examples from the family, as well as an example from the clinician to encourage generalization (e.g., "I was nervous before assembly yesterday—but I went in anyway and it was fine," "There's nothing dangerous about assembly," "Listening to the assembly helps me realize nothing scary is going to happen," "I can do this"). The potential value that Laura's parents could add in supporting her (and themselves) to find more helpful ways of looking at things by considering evidence for and against fears, as well as alternative perspectives, was discussed. As homework, the family agreed to practice coping self-talk using a shortened CBT thought record. This aimed to increase awareness and understanding of fearful thoughts and their triggers in Laura and her parents, and to facilitate practicing coping self-talk. The clinician gave a detailed information sheet on coping self-talk for Laura's parents to discuss together at home, which summarized the content of the session discussion. The main points from this information sheet were briefly explained in the session but not discussed further because Laura's parents said that they would be motivated to read the material at home.

Treatment Session 5 involved discussing the evidence base regarding how parents can help their children face fears and increase self-confidence, using recent examples from the family. This session aimed to challenge cognitions in Laura's parents that influenced the messages they sent to Laura about the world and herself via their behaviors, and to challenge Laura's fears. Specifically, this discussion covered that Laura might be more capable and less fragile than her parents currently perceived; that to counter Laura's bias of the world as a threatening and dangerous place, it might be more helpful to send messages conveying that the world is generally safe and that Laura can cope; that for Laura to develop age-appropriate independence, her parents would need to tolerate her experiencing some degree of distress in the short term (and that this would not mean that they are "bad parents"); that being consistent in their parenting style and cooperating and supporting each other would be helpful; and that encouraging and reinforcing trial and error learning (rather than taking control of tasks or permitting avoidance) would help Laura to continue to develop useful coping strategies and a sense of control over feared situations (Bögels & Brechman-Toussaint, 2006; Cartwright-Hatton et al., 2010). An information sheet summarizing the discussion was given for Laura's parents to discuss together as homework. The clinician did not broach Laura's parents' own early experiences/the parenting they themselves received and how this may be influencing their parenting behaviors because (a) they did not present with or report any mental health problems, (b) some research indicates that parenting *behaviors* are more important than the presence/absence of a parental psychological disorder (Creswell, Jilletts, Murray, Singhal, & Cooper, 2008), (c) Laura's parents did not see this as a relevant focus, and (d) the family were making excellent progress without this discussion having taken place.

The penultimate session was spent summarizing and discussing the treatment content to date and reviewing distance from goals. The family's goals had been reached, so a plan was made to focus the next session on relapse prevention. The final session was spent working through a

relapse prevention workbook that the clinician created based on the literature, with an equal focus on Laura and her parents' thoughts and behaviors. The workbook starts with two questions that facilitate consideration of what the family found helpful from the work together, so that this information is available in the future. Most of the session was spent identifying and planning for potential setbacks using if–then plans (implementation intentions) that specify when and where useful skills and knowledge will be used. Implementation intentions are simple but highly effective cognitive strategies that make it more likely that helpful skills and behaviors will be used when needed (Gollwitzer & Sheeran, 2006). Goals were then made for the subsequent three months to maintain progress once the sessions had finished.

8 Complicating Factors

The most significant complicating factor in working with this case was the lack of information regarding Laura's fear cognitions and Laura's parents' own mental health. As described, Laura's developmental level meant that specific cognitions either were not present or could not be described, so the clinician inferred key cognitions from discussions of triggers and parent reports. Laura's parents denied any current or previous mental health problems and these did not seem apparent in Laura's or her parent's presentation. However, further information concerning Laura's parents' mental health, gathered via clinical interview or self-report measures, would have corroborated the self-reports and provided reassurance that important clinical information had not been overlooked. As is often the case in child working, throughout treatment, Laura was presented as having/being "the problem," rather than the problem being multifaceted and consisting of individual and relational aspects. This narrative meant that Laura's parents did not consider the origins of their less helpful parenting cognitions and behaviors to be relevant to the presenting problems and intervention. However, they were happy to discuss their parenting cognitions because these were "about Laura." The clinician used a hypothesis testing, collaborative approach and worked with the parenting cognitions and behaviors themselves as agreed. However, had working with parental cognitions and behaviors in this way not led to improvement, the clinician would have collaboratively explored potentially missing parts of the formulation such as the origins of unhelpful parenting beliefs. There were few other complicating factors. Laura had no comorbid psychological problems and she and her family presented as highly motivated to overcome unhelpful fears and coping behaviors throughout treatment. A different clinical presentation may have warranted assessment and intervention with the school system (e.g., consultation or indirect CBT).

9 Access and Barriers to Care

Because Laura was referred through the usual channels and had adequate transportation and financial resources, there were no accesses or barriers to care considerations.

10 Follow-Up

Over a period of two months and seven sessions, Laura and her parents made substantial changes. Prior to treatment, Laura demonstrated significant distress and impaired functioning, and her parents and school were unsure how to overcome her anxiety problems. After the intervention, Laura's avoidant behaviors and anxiety symptoms were mostly reversed, her functioning improved markedly, parents and teachers became more confident in helping her anxiety problems, and she and her parents recognized and focused on Laura's strengths and resources more frequently. These changes suggest that the clinician's formulation was supported (or at least helpful) and that a balanced consideration of parent and child factors can lead to fast and significant therapeutic gains in

Table 2. Laura's Pre- and Post-treatment Clinical Scores.

SDQ subscales	Pre-treatment	Post-treatment
Hyperactivity/inattention	3 (close to average)	0 (close to average)
Emotional symptoms	10 (very high)	4 (slightly raised)
Conduct problems	1 (close to average)	1 (close to average)
Peer relation problems	2 (close to average)	2 (close to average)
Prosocial behavior	7 (slightly low)	9 (close to average)
Total difficulties score	16 (slightly raised)	7 (close to average)
Impact on functioning	10 (very high)	0 (close to average)

Note. The descriptions are based on U.K. normed data such that in the general population roughly 80% of children score "close to average," 10% score "slightly raised," 5% score "high," and 5% score "very high." The prosocial behavior subscale is scored opposite such that roughly 80% of children score "close to average," 10% score "slightly low," 5% score "low," and 5% score "very low." SDQ = Strengths and Difficulties Questionnaire.

CBT for child anxiety problems. The outcome of this intervention was very positive and the family was collaboratively discharged from CAMHS because their goals had been achieved. The most important change in functioning was Laura's full-time return to school, but many other avoidant behaviors and anxiety symptoms were also reversed. When compared with norms, Laura's SDQ subscores reduced from "very high" at assessment to "close to average" post-treatment and the presenting problems no longer significantly impaired Laura's or her parents' functioning (Table 2). Laura's fear and avoidance ratings (SUDs) reduced over time, and she reported significantly reduced endorsement of fears. Laura also became more confident during sessions and her parents reported increased confidence in parenting Laura's fears and distress.

11 Treatment Implications of the Case

The current case study illustrated in detail how to involve parents and children alike in all stages of CBT for child anxiety problems. It also illustrated the benefits of adopting a flexible, individualized approach, rather than strictly adhering to a therapy manual; CBT techniques were specifically selected to target only those factors hypothesized by the case conceptualization to be critical to the development and maintenance of child anxiety problems for this specific family, at this specific time. We hope that describing the interplay between child anxiety theory and evidence, emerging clinical information, and the clinician's thinking and decision making illustrated how clinicians and students can coherently and flexibly link theory, research, and practice in this important area.

We have observed considerable professional debate in the literature and in practice regarding whether and how parents can be involved in child anxiety (and other) treatment; some clinicians and therapeutic models endorse working with children alone, other endorse working with parents alone. Parental involvement in treatment is inevitable to at least some extent, because parents usually initiate referrals and bring children to sessions (Stallard, 2005). These factors are especially the case for younger children. As we have outlined, there are clear and strong theoretical and empirical reasons for involving parents in child anxiety treatment. This case study illustrated that rather than an either/or approach to involving parents or children, a both/and approach benefited assessment, case conceptualization, treatment, and evaluation. For the present case, involving just parents or Laura would have missed half of the picture and overlooked potentially valuable information. Ultimately, whether and how parents can be involved in child anxiety (and other) treatment remains an ongoing empirical question for future research to determine, but we hope that this case study has illustrated how parents can be thoughtfully incorporated into child anxiety CBT.

12 Recommendations to Clinicians and Students

The current evidence from randomized controlled trials is surprisingly inconclusive regarding how and when to incorporate parents into CBT for child anxiety problems and whether doing so does indeed improve outcomes (Breinholst et al., 2012; Creswell & Cartwright-Hatton, 2007). Future research is clearly needed to empirically examine how and when family (and other) systems can be incorporated in CBT for child anxiety and other problems (see Breinholst et al., 2012; Creswell & Cartwright-Hatton, 2007, for potential explanations for the current, unexpected trial findings). Such information will be of great interest and use to children and families, clinicians, and those commissioning evidence-based mental health services.

Based on the existing literature for the treatment of child anxiety problems and the experience of working with Laura, we offer four recommendations for clinicians and students intending to treat cases of this type. First, clinicians should be well acquainted with the nature of anxiety problems in children and young people and the use of CBT in this context before attempting to treat young people with anxiety problems. Considerable caution is needed when deviating from established, evidence-based treatment protocols, and clinicians must have clear theoretical and empirical reasons for doing so (Kuyken et al., 2009; Persons, 2008).

Second, we note that one of the weaknesses of this case study was the use of a single, broad, parent-report quantitative measure (relying on verbal-report and SUDs from Laura). There is a plethora of potentially applicable parent-, teacher-, and child-report measures that can accurately measure the multidimensional facets of child anxiety problems (e.g., Behavioral Assessment System for Children, Second Edition [BASC-2]; Screen for Child Anxiety Related Emotional Disorders [SCARED]; and Multidimensional Anxiety Scale for Children, Second Edition [MASC-2]). Whenever practical, we encourage the use of one or more of these measures, measures of parents' own mental health problems, and structured parental assessments that measure parents' beliefs and behaviors that may be pertinent to the maintenance of child anxiety problems. The use of such measures would provide clinically valuable information and enable clinicians (and researchers) to track child anxiety outcomes in the short and long term.

Third, we note the importance of considering developmental factors on a case-by-case basis at all stages of child CBT (Field & Lester, 2010; Grave & Blissett, 2004; Stallard, 2005). For example, when working with this case, the clinician was viewed by Laura as more "credible" than her parents, even though both parties endorsed similar strategies for overcoming Laura"s fears (e.g., exposure to fears). In such instances, clinicians are wise to seek a careful balance between wanting clinical progress while not undermining the confidence or previous successes of parents.

Finally, when working with children with anxiety problems, we suggest that clinicians attend to the process as well as the content of therapeutic interactions. In the present case, the clinician—like Laura's parents and teachers—felt "invited" to perceive Laura as fragile and to condone her avoidance as a way to protect her from short-term distress. Resources such as Waller's (2009) article on "therapist drift" and Safran and Muran's (2000) seminal text on the therapeutic process are extremely valuable in guiding clinicians to recognize and avoid drifting away from evidence-based practice. For example, Waller discusses when clinicians "protect the patient" from the demands of therapy and suggests that this potential problem can be overcome if clinicians view themselves as coaches who teach clients to become their own therapists and by openly discussing with clients that a more adaptive mode of functioning is inevitably going to be distressing in the short term. These approaches were important to consider for this case at the beginning of treatment (the clinician openly discussed with the family what therapy would involve and provided choices) and during the moment-to-moment process of therapeutic interactions. The importance of regular and close supervision that discusses the content and process of clinical cases (including adapting the clinician's personal style to fit the case) cannot be overstated.

Acknowledgments

We are extremely grateful to the family for granting permission to present this case and to the clinician's supervisor and other Child and Adolescent Mental Health Service (CAMHS) professionals for the valuable discussions that informed this case.

Authors' Note

The views expressed in this publication are those of the authors and not necessarily those of the National Health Service (NHS), the National Institute for Health Research, or the Department of Health.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This report is independent research arising in part from an NIHR Career Development Award to SCH supported by the National Institute for Health Research.

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Author Biographies

Andy P. Siddaway, DipCBT, DClinPsy, is a clinical psychologist who recently finished training at the University of Hertfordshire. He has conducted research on several clinical psychology topics and plans a future career in clinical psychology research and practice.

Alex M. Wood, PhD, is a professor and director of the Behavioural Science Centre, Stirling Management School, University of Stirling, which links the behavioral sciences (such as psychology) with the social sciences (such as economics and management) to better understand connections between economic, psychological, and health outcomes and their determinants.

Sam Cartwright-Hatton, DPhil, ClinPsyD, is a clinical psychologist specializing in researching and treating childhood anxiety disorders. She is currently an NIHR career development fellow, developing and testing a preventive intervention aimed at families with an anxious parent. She is based at the University of Sussex.